



MAR 31 2005

Mr. Glenn M. Hackbarth, Chair
Medicare Payment Advisory Commission
601 New Jersey Avenue, N.W., Suite 9000
Washington, D.C. 20001

Dear Mr. Hackbarth:

Pursuant to section 1848(d)(1)(E)(ii) of the Social Security Act, we are providing you with our current estimates of the 2006 physician fee schedule update and conversion factor and the data used in making these estimates. We estimate that the 2006 physician fee schedule update will be -4.3 percent. With the -4.3 percent update, the 2006 physician fee schedule conversion factor will be \$36.2679. As this letter describes, underlying this update is substantial growth in spending for the Medicare services involved.

As you know, the physician fee schedule update is set under a formula specified in section 1848(d)(4) of the Act. Based on this statutory formula, Attachment 1 displays the estimate of the update adjustment factor, and Attachment 2 displays the calculation of the -4.3 percent 2006 update estimate. Section 1848(d) also requires that we provide an estimate of the following year's sustainable growth rate (SGR). Our current estimate of the SGR for calendar year 2006 is 2.5 percent. The SGR is the product of the Secretary's estimate of four factors. We have provided our estimates of these factors in Attachment 3.

The calculation of the fee schedule update depends, among other things, on the cumulative physician fee schedule expenditures from 1996 to 2005. Based on our latest data on spending related to the physician fee schedule, expenditures for 2004 increased by approximately 15 percent. As we noted last week in our analysis for the Trustees Report, this large increase in expenditures related to Part B in 2004 has important ramifications for future Medicare Part B spending by the government and beneficiaries. The further analysis we are reporting here, which includes more complete data from 2004, suggests that the Part B premium increase for 2006 may be about \$1.50 higher than estimated in the Trustees Report. In 2006, beneficiaries will have access to new, highly subsidized prescription drug coverage, as well as a greater range of coordinated-care health plans including PPOs, that will result in average beneficiary savings that substantially exceed the Medicare premium increases. Moreover, beneficiaries living on incomes of around \$1,000 a month or less – perhaps because their only income is from an average Social Security check – generally pay no Medicare premiums. But continued rapid spending growth strains both beneficiaries' incomes and the Federal budget. For this reason, understanding why Part B expenditures are rising so rapidly is of great concern.

We have conducted some preliminary analysis of the 2004 increase in spending for physicians' services. In particular, we were interested in knowing more about both the volume and intensity of the services and the major contributors to growth in those factors.

As noted in the first table in Attachment 4, the vast majority of the 2004 spending growth is attributable to five areas:

- An increase in spending for office visits, with a shift toward longer and more intensive visits, accounted for 29 percent (4.4 percentage points) of the overall spending growth.
- More use of minor procedures accounted for 26 percent (3.9 percentage points) of the overall spending growth. Minor procedures contributing to this increase include therapy procedures performed by physicians and physical therapists, such as manual therapy techniques and neuromuscular reeducation of movement, as well as other minor procedures such as eyelid dermabrasion and chemosurgery. Also contributing to this increase were greater charges for the administration of chemotherapy and other drugs by physicians. To improve the accuracy of drug payments, the Medicare Modernization Act increased payments for drug administration services while decreasing payments for drugs. We anticipate that these two factors had roughly offsetting financial impacts in 2004, and we are reviewing more detailed data now to confirm whether this expectation is accurate. Because of these offsetting impacts, increased utilization of drugs by physicians is likely to be a major contributor to any increase in total spending related to drugs and drug administration. We are conducting further analyses to better understand the overall changes in spending related to drugs administered in physicians' offices.
- More patients are receiving more frequent and complex imaging, such as MRI scans and echocardiograms, accounting for 18 percent (2.8 percentage points) of the overall spending growth. The growth in use of imaging procedures (e.g., cardiac catheterizations) also increased substantially. Growth was much more rapid than in recent years, exceeding 25 percent for advanced imaging procedures such as MRI scans.
- More laboratory and other tests accounted for 11 percent (1.7 percentage points) of the overall spending growth.
- More utilization of prescription drugs in doctors' offices accounted for 11 percent (1.6 percentage points) of the overall spending growth. As noted above, drug payments declined and drug administration fees increased in 2004, as a result of the Medicare law and administrative actions by CMS to make drug payments reflect competitive prices and to assure adequate payment for drug administration. As noted above, we are conducting further analyses of this issue, but the significant increase in drug spending despite large reductions in drug prices suggests that utilization of physician-administered drugs increased substantially.

These numbers are preliminary and may be revised as we examine the spending trends more closely. However, they indicate that the major contributors to the rapid increase in spending appear to be certain diagnostic and therapeutic services, including services particularly important in the treatment of chronic illnesses: more frequent and more intensive followup visits, more frequent and more complex imaging, more frequent and more intensive minor procedures such as physical therapy, more frequent and more complex laboratory tests, and increased use of drugs in physicians' offices. The increase in the number of Medicare beneficiaries between 2003 and 2004 accounts for only a small fraction of the spending growth. Changes enacted by the Medicare Modernization Act such as payment increases for physicians, including the 1.5 percentage-point increase in payment rates for 2004 and the floor on the geographic practice cost index for physician work, accounted for about one-fifth of the spending growth. Because payments to Medicare Advantage plans are not included in physician-related spending, as measured for purposes of the sustainable growth rate system, Medicare Advantage payments were not a factor in the SGR spending growth. (Total Medicare Advantage payments increased by 8.5 percent in 2004, due to the payment rate increase in the Medicare Modernization Act and growth in the number of Medicare Advantage enrollees.)

We would like to understand these concerning trends further, including which changes in utilization are likely to be associated with important health improvements and which ones have health benefits that may be more questionable. Consequently, we intend to discuss the growth in physicians' services and any further analysis and responses to this rapid growth in more detail with physicians and their representatives, as well as other Medicare stakeholders.

As part of this effort, we support MedPAC's recommendation for the development of measures related to the quality and efficiency of care by individual physicians and physician groups. Physicians' decisions are central to the health care their patients receive, and there are substantial variations across geographic areas and similar practices in the use of services—including those accounting for most of the spending growth. We want to work with physicians in this effort to better understand the consequences of differences in the use of followup visits, imaging procedures, laboratory testing, minor therapeutic procedures, and physician-administered drugs for the health of beneficiaries, and to identify ways to provide better support for utilization decisions that clearly increase the quality of care while avoiding unnecessary costs for beneficiaries and the Medicare program.

We are already engaged with the physician community in developing useful measures, and we expect to intensify these efforts given the rapid growth in spending. As an early step in using such measures to improve care, we are now exploring means of sharing information related to quality of care and use of resources with individual physicians. Such data on resource use would not be released publicly except in aggregate. Some measures can be derived from claims data with little or no data collection burden, as a reference point for physicians; for example, information on the frequency and complexity of minor therapy procedures, imaging procedures, lab tests, and visits for their patients with chronic illnesses. We believe that by providing feedback to physicians individually and by working with physician groups to understand and

respond to the overall trends, we can provide more useful information and support their efforts to run more efficient practices.

These steps would build on measures we have implemented as a result of the Medicare Modernization Act to support and reward high-quality, efficient care, including pilot programs for performance-based payments and initiatives to develop better evidence to help patients and physicians make decisions supported by better information about benefits and costs of services. We look forward to working with you, the medical community, and Congress on improvements in our physician payment system that lead to equitable payments to ensure access to high quality and affordable health care, without increasing overall Medicare costs. We are also exploring any potential administrative adjustments to improve the SGR calculation. The rapid increases in physician fee schedule spending in 2004 make these collaborative efforts even more urgent.

We have also provided a more detailed explanation of the SGR and physician fee schedule updates on the CMS web site (<http://www.cms.hhs.gov/providers/sgr/>). All of the data contained in this letter and additional SGR-related information are available to the public in the web site document.

Sincerely,

A handwritten signature in black ink, appearing to read "Herb B. Kuhn", with a stylized flourish at the end.

Herb B. Kuhn
Director
Center for Medicare Management
Centers for Medicare & Medicaid Services

Attachments

Attachment 1

Under section 1848(d)(4) of the Social Security Act, the update for 2006 is equal to the Secretary's estimate of the Medicare Economic Index adjusted by an update adjustment factor and a statutory factor. The formula for the calculation of the update adjustment factor is shown below. The calculation of the update is detailed on the next page.

Estimate of the Update Adjustment Factor

$$UAF_{06} = \frac{\text{Target}_{05} - \text{Actual}_{05}}{\text{Actual}_{05}} \times .75 + \frac{\text{Target}_{4/96-12/05} - \text{Actual}_{4/96-12/05}}{\text{Actual}_{05} \times SGR_{06}} \times .33$$

UAF_{06} = Update Adjustment Factor for 2006

Target_{05} = Allowed Expenditures for CY 2005 = \$79.9 billion

Actual_{05} = Estimated Actual Expenditures for CY 2005 = \$92.9 billion

$\text{Target}_{4/96-12/05}$ = Allowed Expenditures from 4/1/1996 - 12/31/2005 = \$611.2 billion

$\text{Actual}_{4/96-12/05}$ = Estimated Actual Expenditures from 4/1/1996 - 12/31/2005 = \$641.7 billion

SGR_{06} = 2.5 percent

$$\frac{\$79.9 - \$92.9}{\$92.9} \times .75 + \frac{\$611.2 - \$641.7}{\$92.9 \times 1.025} \times .33 = -21.1\%$$

Our current estimate of the update adjustment factor for 2006 is -21.1 percent. The increase in the current estimate compared to last year's forecast of the 2006 update adjustment factor (-21 percent compared to -15 percent forecast for 2006 last year) is attributable entirely to substantially higher actual spending growth in 2004 (15.2 percent) than was previously estimated. Section 1848(d)(4)(D) of the Social Security Act indicates that the update adjustment factor may not be less than -7 percentage points. Consistent with the statute, in the physician fee schedule final rule for 2006 we will limit the update adjustment factor to -7 percentage points if the above formula produces an update adjustment factor that would be less than this value.

Attachment 2

Estimate of the 2006 Physician Fee Schedule Update

(1)	Medicare Economic Index	2.9% (1.029)
(2)	Update Adjustment Factor	-7.0% (0.930)
(3)	Update	-4.3% (0.957)

Note: The figures on lines 1 and 2 are multiplied to produce the update of -4.3% on line 3.

Attachment 3

Estimate of the 2006 Sustainable Growth Rate (SGR)*

(1) Estimated Change in Fees	2.8% (1.028)
(2) Estimated Change in Fee-for-Service Enrollment	-2.5% (0.975)
(3) Estimated Change in Real GDP Per Capita	2.3% (1.023)
(4) Estimated Change in Law or Regulation	0.0% (1.000)
(5) Estimated 2006 SGR	2.5% (1.025)

Note: The figures on lines 1-4 are multiplied to produce the estimated SGR value of 2.5% on line 5.

* These figures represent current estimates only and may change based on new information in a *Federal Register* notice that we expect to publish no later than November 1, 2005.

Attachment 4

Spending Growth Related to the Sustainable Growth Rate

The following table shows the relative impact of various services on the 15.2 percent increase in actual expenditures from 2003-2004 related to the Sustainable Growth Rate (SGR).

Actual expenditures were compared using Berenson-Eggers type of service (BETOS) codes. This system categorizes each procedure code into clinical categories. Office visits have the greatest overall impact on the increase in actual expenditures, though their growth rate was slower than for other major factors. Minor procedures and imaging services rank second and third, respectively, in contributing toward the increase, with disproportionately high rates of growth. Laboratory and other tests are fourth. Drugs are fifth.

Spending Growth By Service Category from 2003 to 2004

Type of Service	Percent of Spending	Percent of Increase	Contribution to Increase
Visits	38%	29%	4.4%
Minor Procedures*	20%	26%	3.9%
Images	14%	18%	2.8%
Laboratory and Other Tests	12%	11%	1.7%
Drugs	10%	11%	1.6%
Major Procedures	6%	3%	0.5%
Other	1%	1%	0.1%
Total	100%	100%	15.2%

* Drug administration codes and physical therapy codes account for more than one-third of expenditures within this coding category.

Analysis Of The Spending Increases By Specialty And By Service Code

We explored the underlying data of the top three categories contributing to overall growth: visits, minor procedures, and images.

Service Code Analysis (Office Visits)

Over the past several years there has been an increasing proportion of office visits in higher-level evaluation and management (E&M) codes. For example, the following table illustrates that, in 1998, of all E&M visits with established patients in physicians' offices, 18 percent of allowed services were Level 2 visits, and 21 percent were Level 4 visits. By 2004, only 12 percent were Level 2 visits, and 26 percent were Level 4 visits. That is, there has been a substantial upward shift in the complexity of billed office visits, with a net increase in the share of office visits at the more complex level. Similar trends occur for other types of E&M visits.

Distribution Across Levels of E&M Codes for Established Patients

Codes	1998	1999	2000	2001	2002	2003	2004
99211	5%	5%	5%	6%	6%	6%	5%
99212	18%	17%	17%	16%	15%	13%	12%
99213	52%	53%	54%	54%	54%	53%	53%
99214	21%	21%	21%	21%	22%	24%	26%
99215	4%	4%	3%	3%	3%	3%	3%

Specialty Analysis (Office Visits)

We examined the rates of increase in office visits by specialty. The table below illustrates the contribution to the rate of increase, by specialty. This table shows that the specialties that are the largest contributors to the growth in office visits are also the specialties with the highest volume of office visits: internal medicine; family practice; and cardiology.

Spending Growth in Office Visits from 2003 to 2004, By Specialty

Specialty	Percent of Spending	Percent of Increase	Contribution to Increase
Internal Medicine	28%	25%	3.8%
Family Practice	19%	21%	3.2%
Cardiovascular Disease	8%	9%	1.4%
Orthopedic Surgery	4%	4%	0.7%
Dermatology	3%	4%	0.5%
Podiatry	3%	3%	0.5%
Urology	3%	3%	0.5%
Neurology	2%	3%	0.4%
Nurse Practitioners	1%	2%	0.4%
Pulmonary Disease	2%	2%	0.4%
Physicians Assistant	1%	2%	0.3%
Gastroenterology	2%	2%	0.3%
Nephrology	1%	2%	0.2%
Endocrinology	1%	1%	0.2%
Otology,Laryn., Rhino.	2%	1%	0.2%
Interventional Pain Mgt	0%	1%	0.1%
Rheumatology	2%	1%	0.2%
Optometry	1%	1%	0.2%
General Practice	3%	1%	0.2%
Physical Medicine And Rehab.	1%	1%	0.2%
Hematology/Oncology	3%	1%	0.2%
Other	12%	9%	1.4%

Service Code Analysis (Minor Procedures)

The greatest contributors to the increase in this service category are drug administration and physical therapy. The large increase in expenditures for drug administration is due to the higher payments established for these codes as a result of the MMA; the payment increases occurred in conjunction with offsetting reductions in drug prices, so that changes in drug utilization are likely the most important contributors to overall drug spending growth (we are investigating this further). Other minor procedures contributing to this increase include therapy procedures performed by physicians and physical therapists, such as manual therapy techniques (code 97110), and neuromuscular reeducation of movement (code 97140) (as well as other minor procedures such as eyelid dermabrasion and chemosurgery, which are not shown in the following table). The following table shows the increases in charges and services during 2004 for codes that contribute over 90 percent of the overall growth in this category.

Code	Description	Increase In Charges	Increase In Services
Drug Administration			
90780	Intravenous infusion, nonchemotherapy	202%	11%
90782	Therap., proph., diag. Injection, nonchemo	635%	43%
90781	Intravenous infusion, nonchemo, add. Hour	76%	15%
96408	Chemotherapy, push technique	409%	25%
96410	Chemotherapy, infuse method	287%	6%
96400	Chemotherapy, sc/im	144%	11%
96412	Chemo, infuse method add on	22%	12%
Therapy Services			
97110	Therapeutic Proc., one or more areas, each 15 mins.	24%	18%
97112	Neuromuscular reeducation of movement	26%	22%
97140	Manual therapy techniques, one or more regions, each 15 mins.	24%	20%

Specialty Analysis (Minor Procedures)

The BETOS category of minor procedures includes skin, musculoskeletal, and other procedures, including therapeutic services, infusions, and injections. We examined the rates of increase in minor procedures by specialty. The table below illustrates the contribution to the rate of increase, by specialty. Similar to the analysis by specialty of the relative contribution of each specialty to the increase in spending for minor procedures, this analysis lists the specialties in descending order relative to their contribution to the increase in 2004 spending.

Spending Growth in Minor Procedures from 2003 to 2004, By Specialty			
Specialty	Percent of Spending	Percent of Increase	Contribution to Increase
Physical Therapist (Indep. Practice)	19%	24%	3.6%
Hematology/Oncology	4%	12%	1.8%
Dermatology	11%	6%	0.9%
Medical Oncology	2%	5%	0.8%
Internal Medicine	5%	5%	0.7%
Ambulatory Surgical Center	4%	4%	0.6%
Podiatry	10%	4%	0.6%
Orthopedic Surgery	7%	4%	0.6%

Family Practice	4%	4%	0.6%
Urology	4%	4%	0.5%
Physical Medicine	3%	3%	0.4%
General Surgery	2%	2%	0.3%
Rheumatology	2%	2%	0.3%
Occupational Therapist	1%	2%	0.3%
Anesthesiology	4%	2%	0.2%
Gynecology	1%	2%	0.2%
Radiology	1%	2%	0.2%
Infectious Disease	1%	2%	0.2%
General Practice	2%	1%	0.2%
Ob-Gyn	1%	1%	0.2%
Diagnostic Lab.	1%	1%	0.2%
Neurology	2%	1%	0.2%
Emergency Medicine	1%	1%	0.2%
Nephrology	0%	1%	0.2%
Otology, Laryn., Rhino.	1%	1%	0.2%

Service Code Analysis (Imaging Procedures)

The volume of imaging services have been growing more rapidly than other services for several years. However, the 2004 increases in imaging expenditures are substantially higher than prior year's increases. Advanced imaging, the BETOS subcategory for CAT and MRI scans, had the highest one year increase in expenditures. Imaging/Procedure, a subcategory that includes cardiac catheterization, was second.

Year-to-Year Increases in Expenditures for Imaging Services				
	2000-2001	2001-2002	2002-2003	2003-2004
Standard Imaging	6.5%	7.1%	3.9%	18.9%
Advanced Imaging	17.5%	16.1%	12.6%	25.8%
Echography	11.3%	12.8%	5.5%	19.3%
Imaging/Procedure	10.5%	19.4%	13.6%	23.2%

Specialty Analysis (Imaging)

We also examined the rates of increase in imaging by specialty, as shown in the following table.

Spending Growth in Imaging Procedures from 2003 to 2004, By Specialty

Specialty	Percent of Spending	Percent of Increase	Contribution to Increase
Radiology	41%	35%	5.3%
Cardiology	26%	29%	4.3%
Diagnostic Testing Facility	8%	12%	1.8%

Internal Medicine	6%	6%	0.9%
Orthopedic Surgery	3%	2%	0.4%
Family Practice	2%	2%	0.3%
Psychologist (Billing Independently)	2%	1%	0.2%
Vascular Surgery	1%	1%	0.2%
Nuclear Medicine	1%	1%	0.1%
Hematology/Oncology	0%	1%	0.1%
Radiation Oncology	1%	1%	0.1%
General Practice	1%	1%	0.1%
Gastroenterology	0%	1%	0.1%
Interventional Radiology	1%	1%	0.1%
General Surgery	1%	1%	0.1%
Neurology	1%	1%	0.1%
Urology	1%	1%	0.1%
Anesthesiology	1%	0%	0.1%
Gynecology (Osteo)	0%	0%	0.1%
Physical Therapist (Indep. Practice)	0%	0%	0.1%
Medical Oncology	0%	0%	0.1%
Nephrology	0%	0%	0.1%
Physical Medicine	0%	0%	0.1%
Ambulatory Surgical Center	0%	0%	0.1%
